AHRQ's Primary Care Practice Facilitation Forum

PCMH Resource Center

The primary care medical home, also referred to as the patient centered medical home (PCMH), advanced primary care, and the healthcare home, is a promising model for transforming the organization and delivery of primary care. We provide implementers, decisionmakers, and researchers with access to evidence-based resources about the medical home and its potential to transform primary care and improve the quality, safety, efficiency, and effectiveness of U.S. health care. Please visit us at http://pcmh.ahrq.gov.

This electronic newsletter continues our efforts toward building a learning network for individuals with an interest in practice facilitation. We will use this listserv to share questions and answers submitted by learning forum members, as well as resources, research articles, and events of interest to the community.

Key Concepts in Practice Facilitation
Assessing Practice Readiness for Change

How to Determine if a Primary Care Provider is Likely to Benefit from Practice Facilitation

Though practice facilitation is a valuable resource for health care providers, not all practices are in an ideal position to benefit from working with a practice facilitator. Before beginning an intervention with a practice, it is important to first conduct an assessment of the practice's readiness for facilitated improvement work. This figure in Module 12 of *The Practice Facilitation Handbook* contains criteria for assessing practice readiness. However, not every practice meeting these criteria will be successful in a facilitated improvement intervention, and some practices that do not meet these criteria may still benefit from facilitation.

Practices that seem ready for facilitation should be reassessed 3 months after beginning facilitated improvement work. This second assessment should take into account the initial readiness criteria while also considering attendance at project meetings, progress in developing quality improvement plans, and follow-through on action items. If a practice fails to meet most readiness criteria after 3 months, the facilitator may want to consider whether to continue the intervention, step back from facilitation work until a later time when the practice is better prepared to engage, or bring in additional support.

For more information on assessing practice readiness for change, see Module 12 of *The Practice Facilitation Handbook: Training Modules for New Facilitators and Their Trainers*. You can download a PDF copy of the entire handbook free of charge at the PCPF Resources page of AHRQ's **PCMH Resource Center**.

Perspectives from the Field

This week Mary Ruhe, an experienced practice facilitator and currently a graduate student in the Family Nurse Practitioner program at The Ohio State University College of Nursing, talks with us about how to determine whether a practice is likely to benefit from practice facilitation.

What criteria do you feel are most indicative of a practice's readiness to change?

"Assessing a practices' capacity for change requires consideration of motivation, aptitude and what I think of as a little bit of joy. When I think of a practice that is ready and able to change, I envision participants who have a compelling capacity in any of these three qualities. Motivation can come from a sense of mission, a desire for improvement/excellence, or an honest acknowledgement of need. Aptitude can include experience, expertise, or untapped potential. The little bit of joy is reflected through a positive morale and a spark of optimism in the work environment."

What types of practices are in the best position to benefit from practice facilitation? What tools and techniques are useful for determining whether a practice is likely to benefit from working with a practice facilitator?
"The type of practice most likely to benefit from practice facilitation is one that has done some self-reflection. An important tool for assessing successful practice facilitation collaboration is a facilitator that is recognized as an unbiased advocate for the practice. A practice open to change will self-identify their needs and barriers if they feel safe in sharing."

What factors may inhibit a practice from being receptive to practice improvement work?
"Two factors that most often get in the way of practice improvement are competing demands and conflictual relationships. Competing demands can often be overcome by cohesive teamwork. Conflictual relationships can often be superseded by shared goals. The combination of the two represents a major hurdle to sustainable practice change."

(The views expressed here are those of Ms. Ruhe and do not necessarily represent the views of AHRQ. No statement in this newsletter should be construed as official position of AHRQ or of the U.S. Department of Health and Human Services.)

Be on the lookout for another reader response on this topic in next week's newsletter!

What Do You Think?

Ms. Ruhe mentions several factors that may impact a practice's ability to benefit from facilitated improvement work.

What do you think are important issues to consider when assessing a practice's readiness for change?

Please join the discussion by sending your thoughts to us at PracticeFacilitation@mathematica-mpr.com*. We look forward to receiving your responses and sharing them in a future newsletter.*

Publication of Interest

Singh H, Meyer A, and Thomas E. **The Frequency of Diagnostic Errors in Outpatient Care: Estimations from Three Large Observational Studies Involving US Adult Populations**. BMJ Quality and Safety 2014.

Published Abstract:

Background: The frequency of outpatient diagnostic errors is challenging to determine due to varying error definitions and the need to review data across multiple providers and care settings over time. We estimated the frequency of diagnostic errors in the US adult population by synthesizing data from three previous studies of clinic-based populations that used conceptually similar definitions of diagnostic error.

Methods: Data sources included two previous studies that used electronic triggers, or algorithms, to detect unusual patterns of return visits after an initial primary care visit or lack of follow-up of abnormal clinical findings related to colorectal cancer, both suggestive of diagnostic errors. A third study examined consecutive cases of lung cancer. In all three studies, diagnostic errors were confirmed through chart review and defined as missed opportunities to make a timely or correct

diagnosis based on available evidence. We extrapolated the frequency of diagnostic error obtained from our studies to the US adult population, using the primary care study to estimate rates of diagnostic error for acute conditions (and exacerbations of existing conditions) and the two cancer studies to conservatively estimate rates of missed diagnosis of colorectal and lung cancer (as proxies for other serious chronic conditions).

Results: Combining estimates from the three studies yielded a rate of outpatient diagnostic errors of 5.08%, or approximately 12 million US adults every year. Based upon previous work, we estimate that about half of these errors could potentially be harmful.

Conclusions: Our population-based estimate suggests that diagnostic errors affect at least 1 in 20 US adults. This foundational evidence should encourage policymakers, healthcare organizations and researchers to start measuring and reducing diagnostic errors.

Click here to access a full text PDF of the article.

Relevant Resource:

Improving Your Office Testing Process: A Toolkit for Rapid-Cycle Patient Safety and Quality Improvement

Ensuring that test results are not lost or misplaced is a critical part of reducing diagnostic errors. Approximately 40 percent of primary care office visits involve some type of diagnostic medical test, such as a urine sample or blood test, provided on site or at a laboratory. However, if test results are lost, incorrect or incomplete, the wrong treatment may be prescribed and patient harm can occur. AHRQ's Improving Your Office Testing Process toolkit provides information and resources to help doctors, nurses and medical office staff improve their processes for tracking, reporting and following up with patients after medical laboratory tests.

This toolkit and other resources are available at no cost on AHRQ's Quality and Patient Safety portal.

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